H-E-A-R SAY

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Should is a 4 Letter Word

In English, the expression *four-letter word* is used to indicate profanities so abhorrent that they can only be referred to obliquely to avoid the total collapse of civilization.

Interestingly, the ever efficient Dutch require only three letters to express the same sentiments.

Irresponsible use of *should* can lead to such terrible consequences in accident investigation and problem solving that the only solution is to classify it as a four-letter word, to be avoided at all costs. After something has gone wrong, such as an accident or incident, it is the easiest thing in the world to state how people *should* have behaved or what *should* happen in the future to prevent the same thing from happening again. In truth, the word *should* is very dangerous in this context, since it is about aspiration rather than action; until you do something in real life, you have done nothing to modify the probability of the incident recurring.

To illustrate the pervasive use of *should*, consider the following extracts typical of the recommendations contained in the US Coast Guard Deepwater Horizon report:

- ...requirements *should* be established for the continued inspection, repair and maintenance of electrical equipment in hazardous areas...
- ...unified guidelines for performing the required blast resistance calculations *should* be developed.

Of course these are good ideas, but they achieve nothing until they become reality, and there are many pitfalls along that road. Will they ever be implemented, how long will it take, and how many casualties will there be in the interim?

While it is easy to pick on the Macondo event, the *should* problem is not unique to the oil and gas business, or to industry in general. It appears to be a human or societal failing.

Every day the National Health Service in the UK provides great health care to hundreds of thousands of patients. In the mid-1980's, however, concerns began to be raised at one hospital in Bristol, England, specifically related to a higher than normal mortality rate for infants who had undergone cardiac surgery there. The medical establishment failed to act for many years, and it was largely a series of articles in the British muck-raking periodical "Private Eye" in 1992 that finally forced the matter into the open. Even then, it took until 1998 for a Public Inquiry to be set up, which did not report until July 2001.

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The Public Inquiry reported that, in the period from 1991 to 1995, between 30 and 35 more children under 1 year old had died after open-heart surgery in the Bristol Unit than other comparable units in England at the time.

Even more sensationally, the Public Inquiry report stated "Around 5% of the 8.5 million patients admitted to hospitals in England and Wales each year experience an adverse event which may be preventable with the exercise of ordinary standards of care. How many of these events lead to death is not known but it may be as high as 25,000 people a year."

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Inside this issue:

Number Crunching

$40 billion (and counting): Estimated cost of cleanup and compensation after the Macondo well blowout.

$10 million (minimum estimate): Estimated value of shortcuts taken for completion of Macondo well.

5 days: Spill response training to prepare for the next big disaster.

1 day: vPSI training to develop real corrective actions to prevent another Macondo.

There is no doubt that the Macondo well disaster has forever changed the face of oil production in the United States. According to the White House initiated National Commission on the BP Deepwater Horizon Oil Spill and Offshore Drilling, the disaster occurred primarily because of cost-cutting measures put in place by BP, Transocean, and Halliburton. In addition, they stated there is nothing put in place by either government or industry that would prevent a similar event from happening.

As stated above, as well as through BP's own admission, the cost-cutting decisions and lack of proper procedures came at a terribly high cost. Horrific as it was, the tragedy in this situation unfortunately goes beyond the loss of lives that resulted from this event. Millions and millions of people, wildlife, and industries were hugely impacted as a result of this disastrous oil spill. Could this disaster have been prevented? Quite simply, yes. It could have easily been avoided by simply recognizing the potential hazard sources and formulating and implementing effective preventive actions that would eliminate or at least mitigate those hazards.

Sometimes, the best means to convey a point is by concrete numbers. Below are some of the real figures that depict just how tragic the Gulf Coast oil spill of 2010 was.

- **36** The number of hours Deepwater Horizon burned before it sank on the morning of 22 April 2010.
- **125** The weight, in tons, of the containment dome placed over the largest leak. Oil was then piped to a storage vessel on the surface. This was BP's initial containment strategy; it failed when leaking gas combined with cold water to create methane hydrate crystals, blocking the pipe way.
- **143** The number of oil spill exposure related health cases recorded by the Louisiana Department of Health between April and June. Cases included 108 working on the clean-up efforts; 35 were working on a voluntary basis. Symptoms included dizziness, vomiting, nausea, headaches, and chest pains.
- **$105 billion** The total value lost by BP between April and June. Investors saw the worth of their holdings fall to $27.02, representing a loss of almost 54%. In July the company's loss in market value totalled $60 billion, a 35% decline since the explosion. BP posted second-quarter losses – the company's first for almost two decades – of $17 billion.
- **$20 billion** The size of BP's "oil spill response fund," created following a meeting between BP executives and US President Barack Obama.
- **$30 billion** The amount of assets the company plans to sell to meet its obligations.

Upcoming Training Classes

The **Fundamentals of vPSI Problem Solving and Accident Prevention** is vPSI Group's core class. It provides attendees with the tools necessary to do a critical analysis of their corrective actions and problem solving efforts.

Classes are continuously offered worldwide. To find out if there is an upcoming class in your area, visit our Eventbrite page or contact us (see page 4 for contact information).

Weaver Brothers, Incorporated

Weaver Brothers is an Alaskan trucking Company with terminals in Anchorage, Kenai, and Fairbanks. They have been providing transportation services to construction, energy, mining, retail and wholesale, warehouse, and government industries since 1946.

Their number one priority is to maintain a "Safety First" culture throughout the entire WBI organization. In 2008 they began applying vPSI methods in their work processes.

Over the past three years they have improved their safe work performance and were recently acknowledged with two prestigious safety awards: The Alaska Trucking Association (ATA) Safe Fleet of the Year for 2010, and the Cottingham & Butler Truck Insurance Group 2011 Best Risk Control Award.

Both awards have stringent requirements. The ATA award is based on the past year's DOT recordable rate and OSHA 300 injury rate while the Cottingham & Butler award recognizes the safest truck fleet out of 30 insured companies and bases their award on the best overall risk management program and lowest loss ratios.

Jimmy Doyle, Weaver Brothers Vice President, maintains, "We feel we have won these awards because of the ever-improving safety culture we have cultivated; we feel this includes applying vPSI methods in our work process."

Congratulations to WBI on your achievements!

Combining Business with Pleasure

vPSI Consultants travel extensively throughout the world but always manage to take a little time out of their schedule to enjoy some of the local dining haunts.

Recently, while in Lake Jackson, Texas, they enjoyed the fantastic menu that Lake Jackson Seafood Restaurant has to offer. Their extensive menu includes almost any imaginable combination of shrimp, catfish, crab and oysters. This is definitely a must for all those seafood lovers out there!

Another local favorite that our consultants discovered while in Surfside Beach, Texas is the Red Snapper Inn, which boasts the slogan, "Our fish spent last night in the Gulf!" It doesn't get much fresher than that!

vPSI Group Director Norman Ritchie recently participated as a panelist in Austin, Texas at the Society of Petroleum Engineers "Applied Technology Workshop: The Journey Continues: Zero Injuries, Zero Incidents." His presentation, "Can Lagging Measures Yield Leading Indicators?," addressed the inadvisability of using trailing indices to predict future incidents. In the midst of trying to revolutionize the industry, Norman still found time to explore some of the many fun and interesting restaurants that this unique city has to offer.

For the adventurous eater who has no problem with eating "nose to tail," he recommends Barley Swine Restaurant, featuring youthful chef Bryce Gilmore. At this favorite local eatery, emphasis is placed on locally sourced ingredients and beers. With an innovative menu using fresh, well-known ingredients in creative ways, Barley Swine continues to elevate the Austin dining scene with Gilmore as one of the city's youngest and most talented chefs.

More vPSI travel photos can be found on our Facebook page.

Should is a 4 Letter Word

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Clearly, such a serious situation demanded a strong response, and the Public Inquiry issued a report containing 198 recommendations.

Here are some typical examples:

- Incentives for reporting sentinel events (near misses) *should* be introduced.
- A system of regulation *should* be in place to ensure that health care professionals acquire and maintain professional competence.
- The quality of health care *should* be regulated through bodies such as the National Institute for Clinical Excellence and the Commission for Health Improvement.

Again, excellent ideas, but none have a path to implementation. In total, the 198 recommendations contained approximately 250 *shoulds*, 70 *musts* and a sprinkling of *should nots* and *must nots*. Unfortunately, such statements about what ought to happen, by themselves, do nothing to deal with the problem in real life.

A recent follow up article in "Private Eye" concluded that, even after 10 years, none of the key reforms identified by the Public Inquiry have been properly enacted or enforced. What can be deduced from this about the current state of UK health care and the cumulative death toll?

Non-UK readers will be unhappy to learn that research by Patrick Hudson (University of Leiden) and others has determined that the issues uncovered by the Bristol Inquiry are not uniquely British, but are present in health care systems all over the world.

Many legal departments require the use of terminology such as *recommend* or *should* in accident investigation reports to soften mandates and allow management an out when things don't get done, but often this causes the organization's efforts at corrections to be emasculated. This is not simply an exercise in semantics. Replacing the word *should* with *must* or similarly stern words is functionally identical unless it is backed up with the means and authority to make it reality.

Keep in mind these key points the next time the word *should* is detected at any point in the accident investigation or problem solving process:

- *Action* is a vital component of the phrase *corrective action*.
- *Should* statements don't *cause action*.
- Don't talk about what *should* happen, instead *cause it* to happen.

It is easy to say what the future should look like; the challenge is to turn that aspiration into reality. Ban the use of *should* in your workplace like other four-letter words. Start a "swear box," levy a penalty for every *should* uttered and donate the considerable money you will make to your charity of choice.

vPSI's Brutal Mirror of Truth

One of our mantras here at vPSI Group is that until you've changed something in reality, your risks and exposures are still out there. We exhort people to examine their corrective actions with the "brutal mirror of truth" to evaluate whether or not the corrective actions will fix what went wrong. Now, thanks to a suggestion from Southwestern Energy's Paul Hart, we have actual Brutal Mirrors of Truth for sale for only $5 plus shipping and handling.

Contact us for more information.

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